

**Utilization Control of Selected Hospitals, Nursing Facility, and Home and Community
Based Services Reimbursed by the Maryland Medicaid Program
Solicitation No: DHMH/OPASS 16-14617
Questions**

WRITTEN

Strategy Horizon Consulting

1. Is there an incumbent Contractor, and if so, could the State please identity the Contractor?

The Delmarva Foundation for Medical Care, Inc. is the current Contractor.

2. If there is an existing Contractor, does the Contractor currently conduct all of the elements in Section 3.2.4 through 3.2.7? If not, which elements are new to the Scope of Work?

The current Contractor conducts all the reviews outlined in this RFP except for Durable Medical Equipment Reviews, Air Ambulance Services, and Home and Community-Based Services Assessments.

3. Could the State provide the cost for the most recent annual contract period (e.g., calendar year 2014)?

The amount of the current contract year (2/1/2015-1/31/2016) is \$5,464,046.

4. Section 3.2.1.5 - Will the contractor use the LTSS/Maryland application to record review results and store related documentation, verify enrollment only, or some other purpose?

The contractor will use the LTSSMaryland system to complete the functions listed in 3.2.1.15 A and B, which include completing medical eligibility assessments via the interRAI tool, completing eligibility reviews for the programs, and completing the auto-validation process. The LTSSMaryland system is used for all work related to the CPAS, CFC, CO, ICS, MDC, and BI programs.

5. Section 3.2.1.6 - The system requirements in this section are in addition to LTSS/Maryland. Does this system need to exchange data with LTSS/Maryland, and if so, what information, how, and with what frequency?

This system does not need to exchange data with LTSS/Maryland.

6. Section 3.2.2.1 - Apparently, one of the three managers does not need to be in the Baltimore area office. Can the State specify which manager could be located elsewhere?

The reference to two managers needing to be located in the Maryland office is an error. The section should read "...three full time managers,..."

7. Section 3.2.2.3 - How many hours does the State consider for an FTE?

Section 1.2.aa defines an FTE as working 40 hours per week.

8. Section 3.2.2.3.C - Does the two FTE Physician Advisors mean two individual physicians or the equivalent of two full-time positions, i.e., roughly 2080 hours each?

This means two physicians, each of whom work full time (40 hours per week).

9. Section 3.2.2.4.A - Are the staff conducting assessments field-based?

Varies, depending on assignments as follows:

Adult Chronic Hospital, Special Pediatric Hospital, Nursing Facility, and Home and Community-Based Services reviews – combination of office- and field-based.

DME Reviews and Air Ambulance Reviews – office based

Acute Hospital Reviews – office based

10. Section 3.2.3.2.A - Do providers call for prior authorization of services?

No.

11. Section 3.2.3.2 - Does the Call Center provide support to Participants and if so, what information/assistance does the Call Center provide, e.g., assistance with obtaining appointments?

Most calls come from Providers following up on or requesting an update on a service request that was submitted electronically. Calls may also come from Applicants, Participants, or their representatives; usually they are requesting information on why their medical eligibility was denied.

12. Section 3.2.4.A.1.c - Please provide an estimate of the percentage of review requests received via hardcopy. Is this method facsimile or mail, or both?

All pre-authorization requests are electronic requests through facsimile and the web based portal.

13. Section 3.2.4.A.4.d - How does this requirement relate to Concurrent Review (as it seems to be Emergency Admission review)?

The concurrent reviews are for both elective and emergency admissions. Section 3.2.4.A.d specifies the review requirement for the emergency admissions, however as indicated in 3.2.4.A.4.b, elective admissions are reviewed based on medically appropriate intervals for participant's condition and diagnosis.

14. Section 3.2.4.A.5.d - How many days do facilities have to submit the medical record after a request from the Contractor?

The facilities must submit complete medical records at the same time the request for the 3808 is initiated. The RFP does not specify the number of days the facilities have to submit medical records after UCA's request; however we accept recommendations to establish the standard.

15. Section 3.2.4.A.6.d - Does the Contractor validate the visit as an emergency based on medical necessity or some other criteria?

The contractor validates that the emergency room services were necessary for treatment of an emergency medical condition.

16. Section 3.2.4.A.7 - Does the State require the Contractor to notify the Participant of reconsideration results?

No.

17. Section 3.2.4.A.9.a - When the Contractor conducts discharge review as part of Concurrent Review, does the Contractor have any responsibility for the planning process, or only to review the facility's performance?

The contractor is only responsible for reviewing the facility's performance.

18. Section 3.2.4.B - What does the Contractor do in these cases, for example simply terminate the review?

The contractor must verify the participant's eligibility for the date of service before the review begins.

19. Section 3.2.4.C - Please clarify what action the Contractor would take regarding denials based on DRG limits.

The denials are based on the medical necessity.

20. Section 3.2.4.C - How does the Contractor issue notices of adverse determinations, e.g., by mail to the provider only? Does the Participant receive a copy of an adverse determination?

The contractor communicates the review determination outcome on the web based portal. They must also send a written notice of adverse determination (via mail) to the facility and participant.

21. Section 3.2.4.D - The Geographic Application seems global; please clarify if this definition applies to Maryland Medicaid Participants only.

Under this Section, the UCA performs acute hospital reviews for all providers meeting criteria for acute care hospitals within the continental United States, for services rendered to Maryland Medicaid Participants.

22. Section 3.2.4.E - For retrospective review, does the Contractor conduct length of stay review on DRG-reimbursed cases?

No, hospitals do not get reimbursed based on DRGs.

23. Section 3.2.4.E - Can providers request reconsideration of a Retrospective Review?

Yes.

24. Section 3.2.5.A.4 - What are the timeframes for request of a reconsideration, and can other parties request a reconsideration or only providers?

The Contractor shall conduct reconsiderations within three business days of receipt of the requests. Reconsiderations may be requested by providers, applicants, participants, or the State (Contract Monitor or designee).

25. Section 3.2.6.1 - What entity conducts Level I and Level II PASRR?

The Level I PASRR review is usually conducted by the discharging hospital or admitting nursing facility, although other health care professionals (e.g., primary care physician) may also complete the form. The Level II evaluation is completed by the Adult Evaluation and Review Service (AERS) office located in the local health department. The State's Developmental Disabilities or Behavioral Health Administration makes the determination, based on the AERS evaluation, of whether nursing facility admission is appropriate.

26. Section 3.2.6.1 - How does the Contractor receive information on PASRR results?

Currently, the Contractor receives information on PASRR results from the nursing facility in the course of onsite review.

27. Section 3.2.6.1.B - Could this determination result in a change in nursing facility eligibility for residents or affect services, such as identifying the need for specialized services?

The Contractor's role in PASRR Review is to determine whether the nursing facility properly identified the need for Level II evaluation and, if necessary, ensured that the appropriate State entity approved nursing facility placement.

28. Section 3.2.6.2.A.2 - What does "evaluation" mean in this context? Can the Contractor disagree with the Level I results, for example? If so, what actions would the Contractor take?

As with the question above, the Contractor's role in PASRR Review is to determine whether the nursing facility properly identified the need for Level II evaluation and, if necessary, ensured that the appropriate State entity approved nursing facility placement.

29. Section 3.2.6.2.A.3 - Please clarify the process by which the Contractor will know on a timely basis if the Participant requires a Level II evaluation and what the determination if a Level II evaluation occurred.

This information is available in the Participant's medical record at the nursing facility, and is currently accomplished through onsite review.

30. Section 3.2.6.2.D - What timeframes apply for Applicants, providers, or the CM to request a reconsideration, and how does the Contractor issue reconsideration notices?

The Contractor shall conduct reconsiderations within three business days of receipt of the requests. The Contractor issues the results of the reconsideration review to the party requesting the reconsideration, using the medium by which the reconsideration was requested (e.g., U.S. Mail, e-mail). If the reconsideration results in the denial being overturned, the Contractor shall also notify the applicant or Participant of the decision via U.S. Mail.

31. Section 3.2.6.2.E - What criteria would the Contractor use to make this determination?

The Contractor shall use clinical judgment in determining whether it is reasonable that the Participant will be able to return home. In making this determination, the Contractor shall take into account the reason for the nursing facility placement and what plans the facility and family have made or are making to bring the Participant home.

32. Section 3.2.6.3 - Please clarify what the State means by formats and media in the context of this requirement.

“Formats” refers to the contents of forms (whether paper or electronic) used to gather data in the course of the review and communications to the provider and Participant regarding the review. “Media” refers to the means by which information is stored or communicated (e.g., paper, computer, fax).

33. Section 3.2.6.3.1 - Please note that the number seems to be inconsistent for this section; should it be 3.2.6.3.A?

Yes, Section 3.2.6.3.1 should read as “Section 3.2.6.3.A”. Thank you for bringing this to our attention.

34. Section 3.2.6.3.1.2 - Does this section mean during the first year of service?

This section refers to a Participant’s first year of Medicaid eligibility for nursing facility benefits.

35. Section 3.2.6.3.B.2 - This item requires review of the records of every individual in each Nursing Facility to establish the due date of the Annual Redetermination.

That is correct.

36. Section 3.2.6.3.B - Please provide additional information about this process. For example, is the review of paper documents, an onsite review, etc.?

This is an onsite review of the Participant’s medical record in the nursing facility.

37. Section 3.2.6.4 - Please provide additional information about this requirement, for example, criteria, notification requirements, reconsideration and appeal rights.

Information regarding this requirement may be found in the Medicaid Program’s Nursing Home Transmittals No. 201 and 233. These Transmittals may be found on the DHMH website at https://mmcp.dhmh.maryland.gov/docs/PT_27_06.pdf (#201) and <https://mmcp.dhmh.maryland.gov/docs/PT25-11.pdf> (#233).

38. Section 3.2.6.5 - Please provide additional information about the performance of this requirement. How does the State require the Contractor to document validation results? Is a separate application required, and does the State require any face-to-face interaction with residents?

The Contractor shall document validation results on a form developed by the State . It is expected that findings will be generated primarily from medical record review and discussions with staff, however some face-to-face interaction with residents may be necessary.

39. Section 3.2.6.5.B - How many providers required reviews that were more frequent because they did not meet the minimum accuracy of 80%, and how many reviews did the Contractor perform?

MDS Validation Reviews are not currently performed, thus no historical data is available. Estimates on the number of reviews expected to be done are provided in Attachment Y of the RFP.

40. Section 3.2.6.6 - How many reviews are out of state?

It is anticipated that no more than 20 reviews annually are for Participants located in out-of-state nursing facilities. If the facility is located more than 25 miles outside the Maryland border, office-based reviews may be done. Currently, only two facilities participating in Maryland Medicaid are located outside Maryland yet within 25 miles of the border.

41. Section 3.2.6.7 - The table contents for Continued Stay Review require review every three months. However, 3.2.6.3.1.2 requires quarterly reviews, which is not precisely the same timing. Please clarify.

The terms “quarterly” and “every three months” should both be interpreted to mean no less frequently than every third calendar month.

42. Section 3.2.6.7 - Please specify if the five days are per facility. How many records did the Contractor verify during 2014 and how many facilities were involved?

The timeframe “five business days” refers to all reviews for a given facility. Currently, 223 nursing facilities participate in Medicaid. The anticipated number of reviews are provided in Attachment Y; it is estimated that Annual Redeterminations of Medical Eligibility will comprise 80 percent of these reviews.

43. Section 3.2.6.7 - Please identify the assessments used in the different waivers.

Since the cited Section refers to Nursing Facility Reviews, we presume that the writer actually meant to reference Section 3.2.7. The assessment instruments used for the various home and community-based programs are:

interRAI HC –MADC, Community Options Waiver, Increased Community Services, Community First Choice, Community Personal Assistance Services

DHMH 3871B – Brain Injury Waiver, Model Waiver, and PACE

44. Section 3.2.7.B.2 - Please identify the specific assessment tool used for this requirement.

This section refers to the interRAI HC tool that is completed in the LTSSMaryland system.

45. Section 3.2.7.B.2 - Is there a Contractor currently conducting this process, and if so, is it the incumbent or another Contractor?

The local health departments and another contractor currently complete the assessments. The LHDs will continue to assess the majority of participants.

46. Section 3.2.7.B - Does the State anticipate conducting annual re-assessments?

Yes.

47. Section 3.2.7.4 - What percentage of the claims submissions are paper?

Currently all submission are done via paper submissions.

48. Section 3.2.7.4 - What criteria does the Contractor use for this review?

The criteria to be used are attached.

49. Section 3.10.3 - Liquidated Damages – please note that the RFP does not contain a section numbered 3.2.6.3.A.

As noted above, Section 3.2.6.3.1 on/about page 49 should read “Section 3.2.6.3.A.”

50. Section 3.10.3 - Are the timeframes for conducting CSR consistent with Section 3.2.6.3? On page 49, the RFP states that the Contractor will conduct quarterly CSRs one year after the initial determination while the Liquidated Damages section states that CSR would occur no later than three months.

Section 3.2.6.3 states that the Contractor shall conduct CSRs at least quarterly (as noted above, this means no less frequently than every third calendar month) for the first twelve month of long term care Medicaid eligibility.

51. Section 4.4.2.6 - Please provide additional information about the State’s expectations for the responses to items (a) and (b) as both require an explanation of how the Contractor will perform work on a section-by-section basis, and therefore seem duplicative.

Section 4.4.2.6.a directs Offerors to describe how its proposed services will meet or exceed State requirements. Section 4.4.2.6.b, on the other hand, focuses on the specific methodologies and techniques for achieving the work.

52. Section 4.4.2.6.e - Does this section mean that Offerors could name employees of the incumbent Contractor as Key Personnel if they were not the incumbent?

Section 4.4.2.6 e does not address Key Personnel. Rather, it obligates an Offeror to affirm that, if awarded this Contract, its employees and agents will not be restricted from working on the next contract. Key Personnel is addressed in Section 4.4.2.7. An Offeror must include individual resumes for Key Personnel and letters of intended commitment to work on the project.

53. Sections 4.4.2.6.e and f - Please clarify what response the State requires to these elements.

See above response.

54. Section 5.2.4 - Please confirm that Offerors should address this element in their responses to Section 3.2.1, for example, 3.2.1.8.

Section 5.2.4 provides that Economic Benefit to the State of Maryland is one of the Evaluation Criteria. The reference in the question to "section 3.2.1, for example ,3.2.1.8" is unclear. Under Section 4.4.2.6 b, Offerors should provide a section-by section Work Plan. The Work Plan should include the requirements of Section 3.2.1. Under Section 4.4.2.15, Offerors are also required to address Economic Benefit factors in their proposals.

Telligen

1. Section 1.3.3.1 - Who are the current minority business organizations and what are the scopes of services performed?

Professional Services Network is the designated MBE for this contract. This company provides nurse staffing to perform reviews.

2. Section 1.3.3.1 - What is the percentage obtained by the current vendor in meeting the minority business goal for each of the the past 2 fiscal years?

The percentage of the MBE participation in the past two contract years is 30.3 percent for 2/1/2013-1/31/2014, and 28.2 for 2/1/2014-1/31/2015.

3. Section 1.4.2 - Does the state have an expected duration for the startup period?

A startup period of 90 days is anticipated.

4. Section 1.4.2 - Can the bidder suggest a startup duration? Is there a maximum start up duration that is acceptable?

The State expects that the successful Offeror will be able to complete transition activities within the 90 day startup period.

5. Section 2.1.3 - Are subsidiaries utilized by their parent company for reviewing, auditing and/or recovering from a provider barred from this procurement?

The RFP bars the Contractor from having an auditing, accounting or any other relationship with any Provider affected by the Contract that, in the sole judgment of the Department, would impair the independent, unbiased work of the Contractor. In submitting a proposal, an Offeror would need to fully disclose any relationships with providers that are subject to Utilization Control activities performed under the Contract. The Department would then determine whether such a relationship is likely to create a conflict of interest.

6. Section 3.2.1.6 - Will users be entering information directly into the contractor's system?

The Contractor's system is required to have the ability to accept applications entered into a portal.

7. Section 3.2.2.2.1 - This section indicates the bidder must have two full time managers in a Baltimore office location. However, section 3.2.2.3.D requires three full time managers. Does this mean the third manager can be deployed in another location or that only two managers will be required?

The reference to two managers needing to be located in the Maryland office is an error. The section should read "...three full time managers,..."

8. Section 3.2.2.3.C - The RFP requires two full time physician advisors. Can this requirement be met by the bidder employing four half time physician advisors rather than two full time physicians?

This means two physicians, each of whom work full time (40 hours per week).

9. Section 3.2.2.3.E - Does the state expect the IT Director specified in the RFP to be devoted 100% to the contract?

Yes.

10. Section 3.2.2.4 - Can the RN staffing requirements specified in this section be met through a combination of full time and part time employees that equal the total FTEs listed in the RFP?

Yes.

11. Section 3.2.2.4.B - This section requires that the bidder have a panel of physician reviewers, but section 3.2.2.3 requires two full time physician advisors. Please clarify the roles of the two full time physician advisors and the panel of physician reviewers.

The full time physician advisors are expected to oversee the review process, including verifying denials and providing expert testimony as needed in hearings. The physician panel members assist with reviews and/or hearings as needed, especially when a certain area of board certification or expertise is needed.

12. Section 3.2.3.1.B - If the contract is awarded to an organization other than the current vendor, will the new vendor inherit any reviews in process that were initiated by the prior vendor? If so, what is the estimated number of reviews that will be transferred? Will the new vendor be responsible for completing any reconsiderations or attending any administrative hearings for cases denied by the previous vendor?

In the event of a transition to a new vendor, the current vendor is expected to complete all work in progress, including attending administrative hearings.

13. Section 3.2.3.5 - Has the state requested any corrective action plans from the current vendor during the prior contract period and if so what did the plans seek to correct and when were they submitted?

Information regarding the current vendor's performance cannot be made available.

14. Section 3.2.4.2 - How many acute care hospitals are typically submitted on hard copy?

All hospitals are submitting pre-authorization requests electronically.

15. Section 3.2.4.A.7 - This review category specifies that reconsiderations are considered part of the original review and are not billable as new reviews. However this language is missing in the description of other review categories. Please clarify when the vendor can bill for reconsiderations as a separate review.

Reconsiderations of previously completed cases are not billable as separate reviews for any program within the scope of this RFP.

16. Section 3.2.5.2.E - What is the volume of certification processing for special pediatric hospitals?

For Special Pediatric Hospitals, certification processing is not a necessary function.

17. Section 3.2.7.1 - Do the 700 reviews specified in the RFP represent the 5% sample for the LTSS validations?

In Attachment Y regarding LTSS validation reviews, the 700 figure is the estimated 5% sample size for year 1. We project that the contractor will complete 700 validation reviews in year 1.

18. Section 3.2.7.1.54.2 - How many standardized assessments were completed in the last fiscal year by month?

Past year assessment data is not a benchmark for volume for this contract as the contractor is not responsible for all assessments, only a portion of assessments as noted in the RFP. There is not a current contractor performing the same scope of work as is requested in this contract. Across programs, there were approximately 15,965 interRAI assessments complete in FY15. This data is not available by month.

20. Section 3.2.7.3.A.1.c - What organization completes the face to face encounters documenting the relationship of the Participant's health status to the prescribed DME?

The professional who is prescribing or ordering the equipment (e.g., physician, nurse practitioner) completes the face-to-face evaluation and documents the findings.

21. Section 3.6.1 - Please provide the current vendor's invoice summary sheet by month for the prior fiscal year?

Information regarding the current Contractor's billing cannot be made available.

22. Section 3.9 - Please provide the last SOC 2 Type 2 annual audit completed by an independent auditor on the current vendor?

Information regarding audits of the current Contractor cannot be made available.

23. Section 3.10 - Has the state assessed any liquidated damages during the past contract period? If so, please provide the reason for each assessment, date assessed amount assessed?

Information regarding the current Contractor's performance cannot be made available.

24. Section 5.2 - What tool is currently used to complete the assessments for the HCBS population?

For MADC, CO, CFC, ICS, and CPAS, the interRAI HC is used. For BI, MW, and PACE, the DHMH 3871B is used.

25. Section 5.2 - Please provide the relative weights for the evaluation factors listed in this section.

The Department does not use a weighting system for the evaluation process.

26. Is the scope of work contained in the RFP significantly different than the work performed by the current vendor? If so, please outline the differences.

The following review activities are new to this RFP: in-home assessments; preauthorization review of selected DME; and air transportation reviews.

27. Are providers reimbursed for their expense to copy and mail medical records to the vendor? If so, will the state treat these as pass through costs or should the vendor include these costs in their proposed unit rates?

The Contractor is not required to reimburse providers for the cost of submitting medical records.

28. Does the state have a budget ceiling for the new contract? If so, please provide it.

The State does not provide this information in a competitive proposal procurement.

Livanta LLC

1. What is the current value of the incumbent's contract?

The current Contract value, including all modifications and option years, is \$24,602,741.

2. Does the state have a budgeted amount for this project? If so, is that budget figure available to bidders?

The State does not provide this information in a competitive proposal procurement.

3. Section, 2.1.2 - Is it acceptable to provide federal contract documents as proof of an Offeror's QIO status?

Yes.

4. Section 2.1.3 - If an Offeror's parent company has relationships with Providers covered under this contract, would it be an acceptable mitigation strategy to firewall Medicaid Utilization Control activities from all parent company activities?

As noted above, the RFP bars the Contractor from having an auditing, accounting or any other relationship with any Provider affected by the Contract that, in the sole judgment of the Department, would impair the independent, unbiased work of the Contractor. In submitting a proposal, an Offeror would need to fully disclose any relationships with providers that are subject to Utilization Control activities performed under the Contract, including relationships held by a parent company or subsidiary.

The Department would then determine whether such a relationship is likely to create a conflict of interest.

6. Section 3.2.1.4 - Does the Contractor have to locate a vendor for the Connect:Direct software, or does the state use a vendor for the Connect:Direct Software and the Contractor just has to pay for it?

The Connect:Direct software is a product of IBM. The vendor will need to contact IBM.

7. If there is an existing vendor for the software, what is the cost of the software?

See above.

8. Section 3.2.1.5 - Is there a cost to Offeror's for the LTSS/Maryland access?

No.

9. Section 3.2.1.10 - Are system updates considered to be in the scope of the contract or can the Offeror be expected to be paid, separately, for system enhancements that are out of the contract scope?

System updates necessary to accomplish the scope of the Contract should be anticipated by the Contractor. Additional payments will not be made to the Contractor.

10. Section 3.2.3.2 d - What is the current Department-approved method for handling calls received after Normal State Business Hours and during State Holidays?

Voice mail may be used for calls coming in after normal State business hours and on weekends and State holidays. The Contractor shall return all such calls by the following business day.

11. Section 3.2.8 - This clause is particularly onerous and not likely to be covered by any business insurance. What is the purpose for requiring the Contractor to be responsible for all direct and consequential damages? Does non-performance of the services include review findings that are disputed and then subsequently overturned? Would the State consider removing this clause from the contract?

The Comptroller, the Treasurer and the Department of Budget and Management have indicated that there should be liquidated damages in our Contracts. We will not remove this from the RFP.

FROM PRE-PROPOSAL CONFERENCE

Livanta

1. Are the physician advisors required to be actively practicing?

No.

2. Section 3.2.8 - Is it the Department's intent to retain the language regarding the Contractor's liability for direct and consequential damages resulting from non-performance?

This language is being retained.

3. What is the total dollar amount of the current contract?

The current Contract amount, including modifications and options, is \$24,602,741.

4. Section 2.1.2 - Please clarify the requirement for a "certification" document to demonstrate that the Offeror is a Quality Improvement Organization (QIO). Currently, the Centers for Medicare and Medicaid Services (CMS) does not provide QIOs with formal certificates.

As noted above, a federal contract document is acceptable to demonstrate that the Offeror is a QIO.

5. Section 3.2.1.9 - Is the capability to process both ICD-9 and ICD-10 required? If so, what happens in situations where both versions are used on the same submission?

Yes, the capability to process both ICD-9 and ICD-10 is required; however, both should not be used on the same submission. Acute hospital discharge dates before October 1, 2015 must use ICD-9 and acute hospital discharge dates after October 1, 2015 must use the ICD-10 code set.

6. Please clarify the difference between "transition" and "start-up."

The term "start-up" refers to the period between the contract award and the go-live date/actual contract start date. The term "transition" as used in describing beginning-of-contract activities specifically refers to those aspects of the work plan that addresses taking over activities from a former Contractor (if applicable) or incorporating new or revised activities (if the same Contractor).

7. Will the Contractor be paid for "start-up/transition" activities before the Go-Live date?

No direct payment is made for services furnished before the Go-Live date, however unit rates during the first year may reflect costs incurred during the start-up/transition time.

8. If a bidding organization is owned in part by an organization that has relationships with providers, is there a mitigation plan to permit the subsidiary organization (bidder) to provide services under the contract?

As noted above, the RFP bars the Contractor from having an auditing, accounting or any other relationship with any Provider affected by the Contract that, in the sole judgment of the Department,

would impair the independent, unbiased work of the Contractor. An Offeror would need to fully disclose any relationships with affected providers, including relationships on the part of a parent company or subsidiary. The Department makes the final determination whether such a relationship creates a potential conflict of interest.

9. May the Contractor use its own systems to carry out functions designated to be performed using LTSS/Maryland?

No, medical eligibility reviews for the Brain Injury Waiver, Medical Adult Day Care, Community Options Waiver, Increased Community Services, Community First Choice, and Community Personal Assistance Services must be processed using LTSS/Maryland. The Contractor may use its own system for programs such as Chronic Hospitals, Special Pediatric Hospitals, Nursing Facilities, the Model Waiver, and PACE, provided that the system meets the operational requirements under Section 3.2.1.

10. Please clarify the definition of full-time. Does the definition allow for vacation, etc.?

Full time is defined being employed at 40 hours per week. An employee may be considered full time even though a reasonable amount of leave is granted. The Contractor is expected to maintain a full level of operations at all times during normal business days/hours.

11. Will the State actively review contractor systems for compliance with encryption requirements, or is this something that the Contractor self-certifies?

The State does not currently have plans to actively review systems for compliance.

12. Section 3.10 – Have there been problems with performance under the contract that has resulted in the State assessing liquidated damages?

The State does not discuss specifics of contract performance. Language regarding liquidated damages, however, is included in other contracts.

13. For Acute Care reviews, from where do the medical records come? Is there a charge to the Contractor?

Medical records are submitted by the hospitals. The Contractor does not pay for these records.

14. What protections are afforded to the Contractor in the event of a legal action? This question is asked in the context of a possible legal action resulting from a Contractor's decision made as an Agent of the Department, based on Departmentally-determined criteria.

The Contractor's rights and responsibilities regarding legal actions are outlined in the Contract boilerplate (Attachment A of the RFP).

Telligen

1. Section 3.2.2.3.C – Can the requirement for two full-time physicians be met through the use of half-time physicians?

No the contract requires these two physicians to be employed full time.

2. Are all three managers required to be based in the Maryland office?

Yes.

3. Is the IT director specified in the RFP required to be devoted 100 percent to the Contract?

Yes

4. Section 3.2.5.2.B - How many Continued Stay Reviews will be done for Special Pediatric Hospitals?

Estimated workload volumes may be found in Attachment Y of the RFP.

5. What organization completes the face-to-face encounters for preauthorizations of DME?

The professional who is prescribing or ordering the equipment (e.g., physician, nurse practitioner) completes the face-to-face evaluation and documents the findings.

The Grant Group

1. Do all three managers need to be office-based?

Yes, these positions are expected to be office-based, although they may sometimes work in the field as necessary.

2. Section 3.2.2.1 – This section requires two managers to be office-based, yet Section 3.2.2.3.D requires three managers. Please clarify.

Section 3.2.2.1 should read that the three managers are office-based.

Miscellaneous Questions

1. Section 3.2.1.6 – This section indicates that the bidder’s data system used to process non-LTSS reviews must have the ability “to automatically approve requests that meet Departmentally-defined profiles”. Please provide an estimate of the proportion on non-LTSS reviews that will be auto approved.

It is expected that for non-LTSS reviews, approximately 50 – 70 percent of reviews would be auto-approved.

2. Section 3.2.2.4 – This specifies the required number of FTEs across the various review categories that must be included in the bidders staffing plan. Are these required staffing levels based on the assumption that all cases will be manually reviewed or did the state factor in the proportion of cases that will be auto approved when the required staffing levels were determined? Can a bidder propose fewer FTEs than the number specified in the RFP if administrative efficiencies and auto approvals will allow the bidder to meet all operational requirements with fewer staff?

The required staffing levels take into account that a certain proportion of medical eligibility reviews will be auto-approved. The minimum staffing levels detailed in the RFP are based on the State’s experience with this contract and the minimum amount of staff needed to carry out the requirements of the contract. Proposals that recommend fewer FTEs than the specified number will be found not susceptible of being selected for award.

3. During the bidder’s conference, the state indicated that providers electronically submit the majority of records for review. Does electronic submission include both fax submissions and submissions through the portal? Can the state provide a more detailed breakdown of the proportion of provider records submitted via fax and those submitted through a portal?

Currently, the providers submit the records via fax, the portal, CD and hard copy through the US Postal Service. A detailed breakdown is not available.